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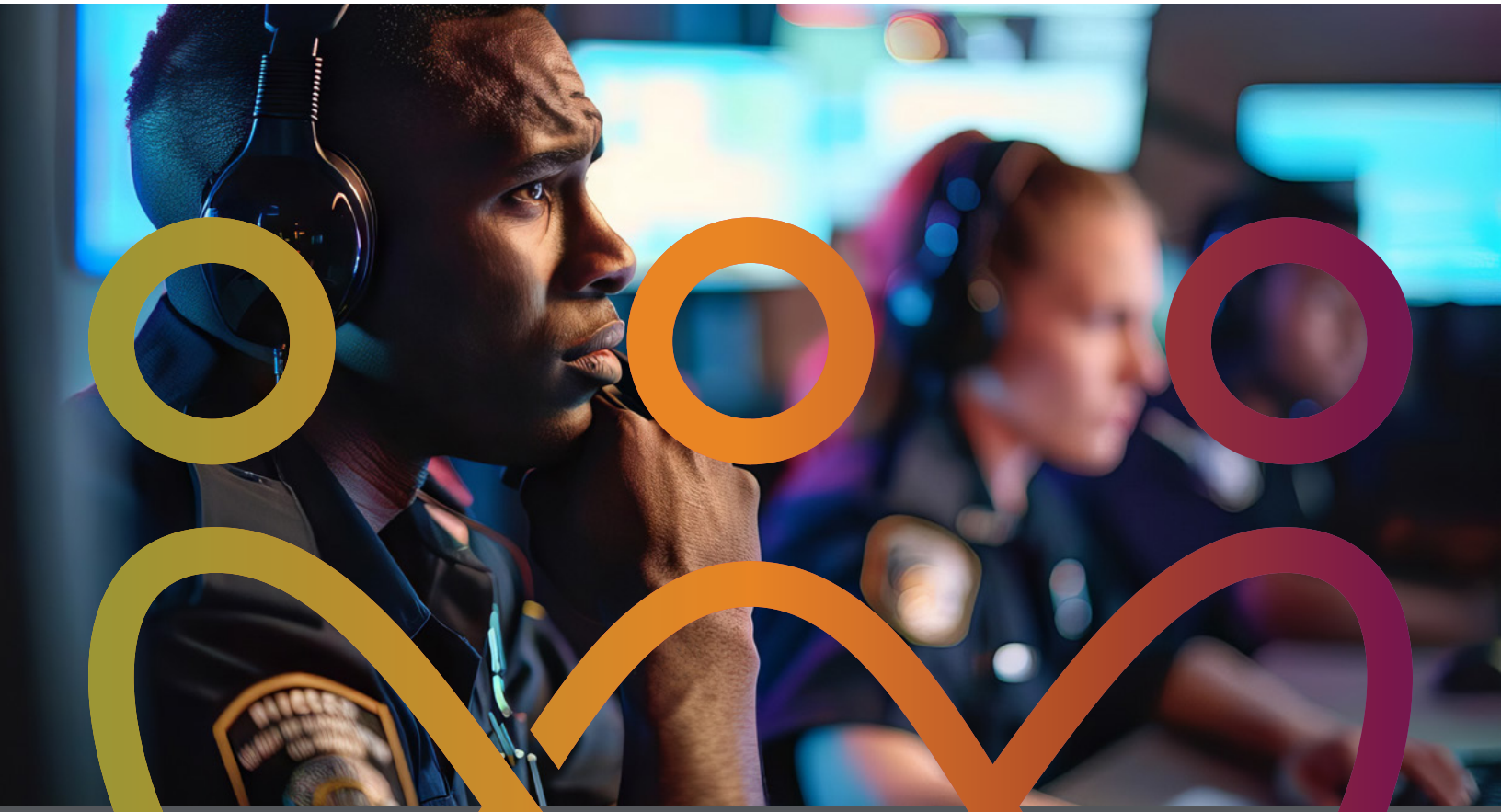

IMPACT REPORT

San Mateo County, California Community Wellness and Crisis Response Team

Pilot program: December 2021 through June 2024

October 2024

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Community Wellness and Crisis Response Team

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by the John W. Gardner Center for Youth and Their Communities

Research Team:
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Introduction

Many 911 calls fielded by police officers in the United States involve a mental health component (Abramson, 2021). Cities and counties across the country have responded by deploying new models of emergency first-response collaborations between police and mental health providers as well as other mental health supports. For more than two decades, San Mateo County has used several models to address community mental health-related crises. These programs include law enforcement first responders who undergo crisis intervention training (CIT), Psychiatric Emergency Response Teams (PERT), and the San Mateo Assessment and Referral Team (SMART). Each of these programs provides support for community members in crisis situations and each relies on partnerships across multiple agencies.

A combination of factors, including input from community organizations and constituents, has led county leaders to seek even more approaches to address mental health crises. To do so, the San Mateo County Executive's Office collaborated with the county's Behavioral Health and Recovery Services (BHRS), StarVista (a nonprofit offering counseling and crisis prevention services), and police agencies within the county's four largest cities: Daly City, Redwood City, San Mateo, and South San Francisco. In December 2021, this partnership began implementing the Community Wellness and Crisis Response Team (CWCRT) Pilot Program, which employs a co-responder model pairing sworn law enforcement officers with mental health clinicians in a first-responder framework.

San Mateo County is not alone in implementing such programs. Various models of collaboration between police and mental health providers have been implemented across the nation, some of which have been studied to assess their effectiveness (Puntis et al., 2018; Seo et al., 2020; Seo et al., 2021; Shapiro et al., 2015; White & Weisburd, 2018). However, previous studies have not established credibly causal relationships between a co-responder program and its key outcomes of interest.

About This Report

This brief, prepared by Stanford's John W. Gardner Center for Youth and Their Communities (Gardner Center), provides early causal evidence on the effects of the CWCRT co-responder program implemented in San Mateo County. The county engaged the Gardner Center to conduct an independent evaluation of its co-responder program implementation and outcomes. The aims of this research are to describe the program, identify factors impacting implementation, follow key outcomes, and highlight opportunities for learning and improvement. This research seeks to inform improvements, guide expansion plans, and broaden the evidence for such programs.

The Gardner Center research team has collected quantitative and qualitative data over the first two years of the pilot program's implementation (December 2021–December 2023), gathering data from participating police agencies, nonparticipating (i.e., comparison) police agencies, and adjacent organizations interacting with the pilot program (e.g., staff of local schools, psychiatric emergency rooms, city and county government, and nonprofit organizations). This effort has included collecting and linking dozens of administrative datasets across nine police agencies, conducting over 60 interviews and 30 observations (including police ride-alongs and dispatch sit-alongs), and reviewing more than 50 program-related documents.

In providing credible causal evidence on key outcomes of interest, this study of the CWCRT Pilot Program is poised to inform research, policy, and practice to advance effective strategies for improving public health and public safety outcomes, locally and nationally. Additional research contextualizing these findings can be found in a series of additional research briefs prepared by the Gardner Center (Gardner Center, 2024a, 2024b, 2024c, 2024d). Together, this collection of briefs provides valuable insights into how the CWCRT Pilot Program contributes to public health and safety in San Mateo County, adding to the growing field of research on promising alternative response models that may improve the outcomes for individuals who call 911 seeking support for mental health-related crises. Following a brief overview of the pilot program's theory of change and a summary of key findings, this report identifies strategic considerations for advancing the pilot program's short- and long-term goals.

Key Findings

The presence of the CWCRT Pilot Program improves incident-level and community-level outcomes. The most significant impact of the program is in the reduction of involuntary psychiatric detentions (also known as "5150s").[1]

The types of calls prompting dispatchers to request a co-responder team rarely result in making an arrest, using force, opening a police case, or logging a criminal complaint. Due in part to the low incidence of these outcomes among program-related calls for service, the presence of the program did not have any detectable impact on these outcomes at the community level.

Over time, the presence of the CWCRT Pilot Program in a community reduces the number of calls for service recorded as "mental health incidents."

Program adoption resulted in:

16%
reduction in involuntary psychiatric detentions

17%
reduction in mental health-focused 911 calls

The Technical Report included in this series details the methodology and formulas used to calculate these program impacts.

1. These actions are pursuant to section 5150 of the Health and Safety Code, which provides legal authority to detain a person involuntarily for assessment, evaluation, and treatment "when a person, as a result of a mental health disorder, is a danger to others, or to themselves; or is gravely disabled due to a mental disorder," defined as being unable to provide for their own basic needs such as food, clothing, or shelter.

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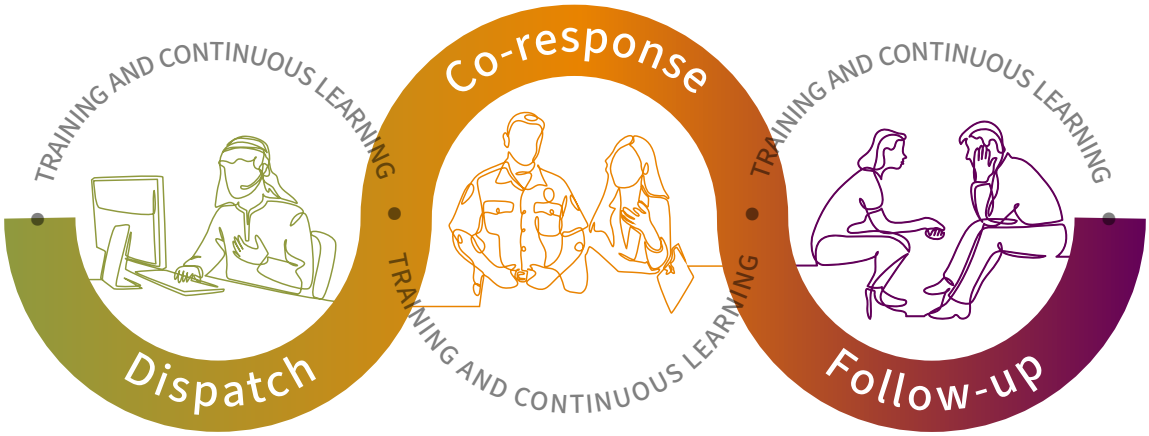


The CWCRT Pilot Program is described in a "Theory of Change" co-created by participants and the research team (Gardner Center, 2024d). The plan articulates specific components and anticipated outcomes of the program and the means through which they are generated. Four core elements are central to the pilot program's design and implementation:

Dispatch. When a 911 call involves a known or suspected mental health component, a "co-responder team" consisting of a law enforcement officer and a mental health clinician is dispatched to the scene.

Co-response. At the scene, the police officer and the mental health clinician function as a co-responder team to address the needs of clients and resolve the situation. The law enforcement officer takes the lead on de-escalating and ensuring the safety of everyone present, including the mental health clinician. Once the scene is secure, the clinician takes the lead on assessing the client and determining the appropriate intervention, such as whether an involuntary psychiatric detention (or "5150 hold") is required, and guiding the client toward appropriate health services.

Follow-up focused on continuity of care. Following the resolution of the call, the mental health clinician makes a follow-up call (typically over the phone) to foster continuity of care and facilitate the client's connection to resources including those available through Behavioral Health and Recovery Services.

Professional development and capacity building. By centering the program on a collaborative response to crises, the pilot program includes formal and informal opportunities for capacity building of individual law enforcement officers and mental health clinicians, their respective agencies and organizations, and cross-sector systems of collaboration.

Co-responder teams respond to emergency calls for service involving a variety of situations and settings. For example:

- A community member calls, requesting assistance because their adult child who lives with them has a severe mental health disorder, is not following their treatment plan, and has barricaded themself in the house;
- A school principal calls, concerned that a student is in imminent danger of harming themselves;
- A community member calls, reporting a car accident involving a parent driver and a critically injured child passenger;
- A community member calls, concerned that someone has been living in a parked car for an extended period of time; or
- A grocery store manager calls, seeking assistance because a customer is threatening to harm himself and others.

Those responding to calls for service encounter these and many other complex situations in which they must gather information quickly, discern best next steps, and respond swiftly. Meanwhile, collaboration among those with different expertise adds another layer of complexity that requires sustained attention within and across all partnering agencies (Gardner Center, 2024a).

Overall, participants expressed a genuine respect for each other's expertise across roles, cities, and agencies. Across the four pilot cities, clinicians report that they value the officer's ability to secure the situation before they interact with the individual in crisis, and officers report that they value the clinician's expertise and perspective, particularly if there is a question about whether to initiate an involuntary psychiatric detention (Gardner Center, 2024a). Further, if it is determined that such a detention is the appropriate next step, the clinician typically completes the required paperwork—reducing the amount of paperwork officers are required to complete and improving the quality of the detention documentation to facilitate improved continuity of care (Gardner Center, 2024c).

Strategic Goals

Program partners theorized that through the implementation of these four core program elements, law enforcement and mental health professionals combine expertise and resources to best serve the public in a timely manner. This, in turn, should improve individual outcomes, public safety, and public health more broadly throughout the county. Partners further anticipated that when a co-responder team is dispatched to a crisis situation involving a known or suspected mental health component, the team will meet the immediate needs of the client and resolve the crisis, as evidenced by short-term outcomes such as reduced rates of use of force, arrests, criminal offenses, and case-to-incident ratio in situations where there is a co-response.

The long-term goals of the pilot program are twofold: (1) to ensure that individuals who call 911 for assistance with a crisis involving a mental health component "experience positive outcomes including but not limited to low rates of involvement with the criminal justice system;" and (2) to improve public safety and public health throughout San Mateo County (Gardner Center, 2024d). Therefore, an evaluation of the program impact requires attention to both individual or "incident-level" outcomes and broader "community-level" outcomes.

Research Approach

Our study of the CWCRT Pilot Program's impacts includes the following research questions:

How does the presence of a co-responder team impact the outcome of an individual call?
We refer to these as "incident-level outcomes." To understand incident-level outcomes, we first determine the types of calls that constitute the majority of calls for service for which a co-responder team is requested by dispatch among the pilot cities that were able to share this information. We then examine the outcomes of those incidents, comparing those that receive a police-only response to those that receive a co-response.

How does the presence of a co-responder program in a community impact the prevalence of each outcome more broadly?
We refer to these as "community-level outcomes." This implies that if incident-level outcomes improve, fewer calls will come through 911 with a mental health component and there will be fewer involuntary psychiatric detentions in that community overall—leading to reduced strain on emergency services. To understand community-level outcomes, we compare outcomes of program-related calls for service in pilot cities to those in cities that do not have the CWCRT Pilot Program (i.e., in "comparison cities").

In our discussion of the three key impact findings, we address both the incident- and community-level impacts of the program by focusing on six call-for-service outcomes documented in police agency data:

1. Arrests[2]
2. Criminal offense
3. Opening of a case
4. Involuntary psychiatric detentions (i.e., "5150 holds")
5. Use of force[3]
6. None of the above[4]

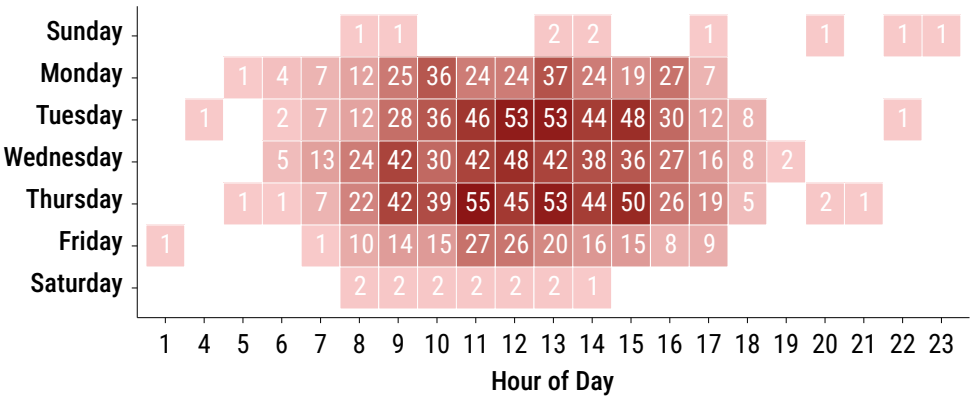
2. Arrest data capture whether an arrest was initiated.
3. The criteria for this outcome vary across police agencies.
4. I.e., no action taken or an undocumented action (conversation with subject, informal referral, etc.).

CWCRT Pilot Program Descriptive Characteristics

Call distribution

Over the first two years of implementation (December 2021–December 2023), co-responder teams arrived at 1,577 calls for service across the four participating cities. The distribution of these calls across days/times, shown in **Figure 1**, reflect clinician's shift schedules. Clinicians tended to work Monday through Friday from approximately 9 a.m. to 6 p.m., during which they would spend part of their time participating in co-responder teams and the rest attending to other responsibilities (e.g., required paperwork, professional development, follow-up, community engagement).

Figure 1 | Distribution of CWCRT co-responses



The time period is December 2021 through December 2023. Darker cells represent higher volumes.

Types of calls to which a co-responder team is dispatched

When logging a call for service, dispatchers select a code from a drop-down menu of options to describe the nature of the call. As described in **Table 1**, 82% of program-eligible calls and 74% of calls to which a co-responder team arrived were coded by dispatchers as welfare checks, mental health incidents, or disturbances. However, these three call types make up just 12% of all calls for service fielded by dispatchers and first responders in the four participating cities.

Table 1. Call-for-Service Types (incidents from December 2021 to December 2023)

	All Calls		CWCRT-Eligible Calls		Calls with CWCRT Responses	
	Number	Percent	Number	Percent	Number	Percent
Welfare Check	17,674	3.5	2,311	51.0	614	38.9
Mental Health Incident	2,458	0.5	899	19.9	364	23.1
Community Disturbance	38,285	7.5	503	10.6	186	11.8
Suspicious Activity	43,352	8.5	203	4.5	52	3.3
Violence or Threats	12,910	2.5	118	2.6	53	3.4
Information Gathering	97,837	19.2	84	1.9	78	5.0
Other	297,971	58.4	400	9.0	226	14.3
TOTAL	**510,487**	**100.0**	**4,538**	**100.0**	**1,577**	**100.0**

Note: Percentages may not add up to 100 percent due to rounding.

An "eligible" call is one that is flagged by a dispatcher or officer as benefiting from a CWCRT response. It does not mean that a clinician was dispatched to the scene.

Demographics of those served

Publicly available data collected and documented by each city's clinician indicate that for much of the pilot period's implementation, those receiving care through the four cities' programs have been roughly 52% male, 45% female, 34% White, 27% Hispanic or Latinx, 12% Black, 11% Asian, 8% reporting another race or ethnicity, and 8% with an unreported race. About 31% of those documented by clinicians were reported as being under 30 years old, while 32% were over 50. A quarter served have been reported as homeless.

Key Impact Finding #1 The presence of the CWCRT Pilot Program reduces the frequency of involuntary psychiatric detentions.

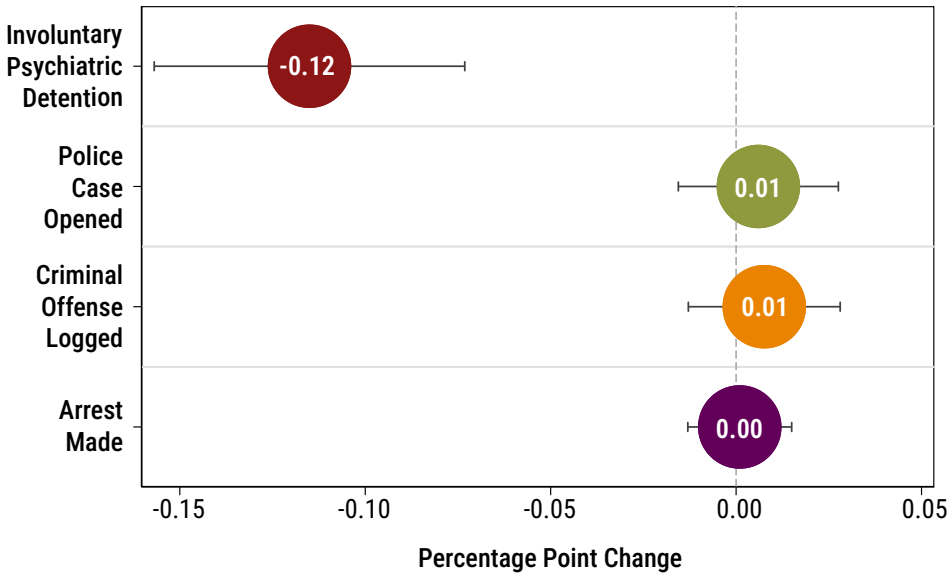
Our analyses suggest substantial and statistically significant effects of program implementation on involuntary psychiatric detentions throughout the participating communities. To recover community-level effects, we rely on comparing data from police areas that do and do not implement the CWCRT Pilot Program—and in months both before and after the program began in participating cities.

Specifically, we find that program adoption resulted in a roughly 16% reduction in the prevalence of involuntary psychiatric detentions. To put these results in context, this estimate implies that the presence of CWCRT resulted in 334 fewer involuntary psychiatric detentions over the first two years of the pilot period, or 84 fewer per agency (see Dee and Pyne [2024] for details).

A supplemental set of analyses identifies the CWCRT program's impact at the moment of emergency response. This analytic approach attempts to isolate the incident-level program impacts by comparing ostensibly similar incidents localized to place and time that do and do not receive a co-response. For example, these models can isolate comparisons to program-eligible calls occurring only in January 2022, on Mondays, and at 3 p.m. to account for seasonal, daily, or hourly variation in the types of calls dispatchers consider for a co-response.

Figure 2 reports the percentage point change in the probability that each of the four outcomes will occur as the result of a CWCRT co-response. Results indicate that a co-response to a program-eligible call for service is associated with a roughly 12 percentage point reduction in the probability that an involuntary psychiatric detention will take place while first responders are on-scene. Meanwhile, there are no statistically significant changes in the probability of a police case being opened, a criminal offense logged, or an arrest.

Figure 2 | Estimated Incident-Level Impacts of a Co-Response



Estimates come from 54 months of data across nine cities in San Mateo County (see Dee and Pyne [2024] for details). Dots are point estimates; bars are 95% confidence intervals.

As described fully in the accompanying technical report by Dee and Pyne (2024), separate estimates of the incident- and community-level effects of the CWCRT Pilot Program suggest that at least half of the effect of the program is due to its prevention of the involuntary psychiatric detentions in the communities served.

Key Impact Finding #2 Over time, the presence of the CWCRT Pilot Program in a community reduces the number of calls for service recorded as mental health incidents.

Dispatchers enter codes for calls for service they receive to signal to law enforcement the general type of incident needing a response. Out of the three main call types associated with the program—mental health, welfare check, and community disturbance—**the CWCRT program resulted in a 17% reduction in the number of mental health-focused calls for service in participating communities**.

These results are consistent with our findings on the reduced rates of involuntary psychiatric detentions, suggesting treated communities are experiencing effective care for those in a mental health crisis. However, the program has no detectable community-level effects on the frequency of welfare check calls or community disturbance calls, and a combined measure of the three CWCRT-related calls for service produced a near-zero estimate of the program's effect (see Dee and Pyne [2024] for details).

Key Impact Finding #3 The types of calls that prompt dispatchers to request a co-responder team rarely result in an arrest, use of force, opening of a police case, or creation of a criminal case.

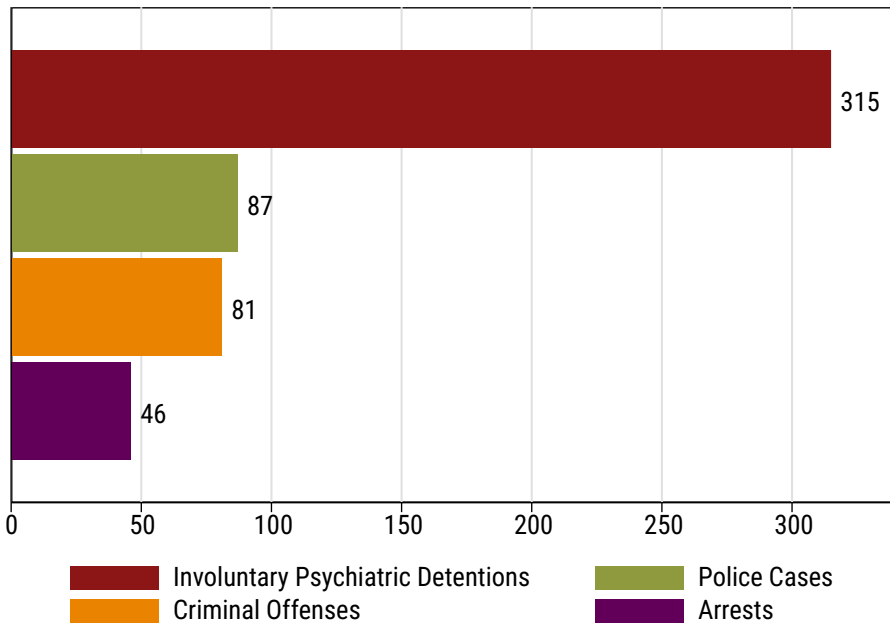
CWCRT partners identified a set of short-term outcomes they hoped to achieve as a result of implementing the co-responder model (Gardner Center, 2024d). Specifically, the pilot cities and the county sought to reduce criminal justice-related outcomes, which include use of force, opening police cases, logging criminal offenses, and making arrests. Our analyses explored the effects of the program on these outcomes at the incident and community levels.

Figure 3 illustrates four of the actions that may occur during a co-response—each of which program partners expect the CWCRT program to affect (Gardner Center, 2024d). Of the 1,577 calls with a co-response among the four cities in the first two years of the program pilot, the majority resulted in no recorded outcome—meaning that the situation was resolved without any additional police action on record. Of the remaining calls, 20% resulted in an involuntary psychiatric detention, 5.5% resulted in a police case being opened, 5.1% resulted in a criminal offense being logged, 2.9% ended in an arrest, and just two involved use of force.

Underscoring a similar null effect of the program on incident-level criminal justice-related outcomes (see Figure 3), we turn once again to the community-level analyses comparing treated cities to comparison cities. We find no causal evidence that the program had effects on criminal outcomes. Additional data suggest correlations between the program and reductions in the frequency of police cases opened, criminal offenses logged, and arrests made. However, these estimates are measured

imprecisely and contain confidence intervals that include a 0% change in frequency of the outcome. Additionally, accompanying robustness checks strongly suggest violations in key assumptions critical to the causal interpretations of these case, offense, and arrest estimates (see Dee and Pyne [2024]). We therefore cannot make causal claims about the effects of the program on these outcomes.

Figure 3. Actions Taken After CWCRT Co-Responses



Frequencies are based on information from 1,577 CWCRT co-responses from December 2021 through December 2023. In 1,046 cases, none of these actions were taken. The two known use-of-force actions occurring during a co-response are not shown.

Strategic Considerations

The CWCRT Pilot Program will continue in the participating cities over the coming years, while expanding to six additional municipalities in San Mateo County. The robust multi-sector partnership framework, trust built across traditionally siloed institutions, and sharing of relevant data among agencies and cities hold promise for the co-responder program to expand. Our findings support several hypotheses motivating the program: specifically, that law enforcement teams respond more skillfully to mental health crises when accompanied by a trained mental health clinician and that this has a favorable impact beyond what happens during a particular emergency call for service (Gardner Center, 2024d).

Additionally, our findings bolster crucial assumptions about the program's impacts. First, the main theory motivating the creation of CWCRT is that police agencies field many calls for service that have a mental health component. This is accurate insofar as data in the four participating cities show that CWCRT clinicians responded to 1,577 calls while on duty, out of about 4,500 eligible calls flagged by dispatchers. However, program-eligible calls comprise less than 1% of the over half a million total emergency incidents logged in these cities during the pilot program. These results invite further exploration into the coding practices used by dispatchers. For example, dispatchers may only include

a mental health code when it is the primary or presenting issue. More detailed coding protocols among police agencies would help further differentiate calls for service that are related to the program's goals from all others that are not.

The CWCRT Pilot Program will continue in the participating cities over the coming years, while expanding to six additional municipalities in San Mateo County.

Some of the distinction between eligible calls that do and do not receive a co-response may also be the result of capacity constraints. For example, if more clinicians are on duty in these cities over more hours of the day and days of the week, clinicians will be able to respond to more program-eligible calls. Understanding the scope of need will require accurate documentation of program-eligible calls for service when clinicians are off-duty or otherwise unavailable (Gardner Center, 2024b) and more clarity on the level of clinician follow-up contact necessary after an initial co-response (Gardner Center, 2024c).

Finally, a primary assumption among partners is that the CWCRT Pilot Program reduces strain on emergency services (Gardner Center, 2024d). The CWCRT Pilot Program's significant reductions in involuntary psychiatric detentions and mental health-related calls for service imply a reduced strain on emergency services—including ones charged with helping those in the midst of a severe mental health crisis. These effects may be the result of skillful provision of immediate mental health services—directing individuals to more appropriate care in the moment of a crisis—or fewer repeated crises occurring to the same individuals because of improved follow-up care.

Topics for Further Research

As alternatives to traditional emergency response systems proliferate nationally, there has been little evidence to guide communities toward the creation and maintenance of effective programs. This research area will benefit from more exploration of how CWCRT and other programs like it alleviate or exacerbate community health and safety systems.

This impact brief presents the first credible causal estimates of a co-responder program's effects on communities in the United States. The causal evidence we present here adds to the nascent, yet growing, body of evidence on alternative emergency response programs, helping communities understand how mental health co-responder programs can benefit both individuals in crisis and their communities at large. Co-responder programs like CWCRT may be a key piece of the ecosystem supporting public safety and public health in San Mateo County and beyond.

Our evaluation of this program in its pilot phase raises additional questions for future research. As CWCRT expands to additional cities and continues in the original pilot cities, we pose questions to inform the continued expansion of co-responder programs across the country.

Impacts of the program

How do co-responder programs affect challenges associated with addressing frequent users of emergency services? Law enforcement partners have noted from the beginning of the CWCRT program that frequent users of emergency services have needs that go beyond the scope of typical police support. Additional research investigating frequent users of CWCRT services will inform the ways co-responder programs alleviate those challenges.

Implementation of program

What is the level of demand for clinician support during the hours when clinicians are not on duty? More may be learned about effective patterns of clinician deployment and the quality of officer-only responses affected by the program when officers have had the opportunity to participate in a co-responder team. Qualitative data suggest officers are developing new strategies that they employ even when clinicians are not present, which may reduce demand for increased clinician staffing.

Given a significant reduction in involuntary psychiatric detentions and related reduced strain on emergency service systems, what is the economic impact of co-responder programs? Mental health crises and the responses associated with addressing them can strain emergency response systems. Reducing mental health crises fielded through 911 services may relieve dispatch centers, free up law enforcement officers to address more serious public safety issues, and reduce intake at emergency psychiatric centers. The benefits may even extend to greater productivity in the labor market as those in crisis are more able to lead stable, productive lives. Understanding the true economic benefits of reducing mental health emergency responses promises to improve finances for cities and counties—and the continued funding of the co-response programs they seek to maintain or scale up.

Data practices

How can we learn more about the people served by co-responder programs? Community members and city participants have asked about the demographics of those served by CWCRT. Currently, in San Mateo County those data are collected solely by clinicians.

To better understand the demographic balance of those served by a co-responder program, researchers will need to investigate both data collection practices and ways to analyze demographic characteristics of those served.

Do co-responder programs have an impact on the prevalence of police use of force? Exploration of the ways co-responder programs affect use of force requires aligning and improving police agency data practices to better investigate this outcome.

In what ways can program-relevant calls be better identified in police agency data? Understanding how dispatchers code calls with a mental health component is essential to better understand program-related criminal justice outcomes. For example, devising a purposive process for specially coding for “mental health,” regardless of the primary incident identifier (e.g., “welfare check” or “disturbance”), may effectively differentiate all calls that are potentially program-relevant from those that would never be likely to activate a co-responder team.

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This impact brief presents the first credible causal estimates of a co-responder program's effects on communities in the United States.

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About the Gardner Center

Stanford's Gardner Center conducts research in partnership with school districts, nonprofits, foundations, and government agencies to generate practical solutions that advance equity for young people and their communities.

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